

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038442

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2830

FILED SEP 23 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN St. Ferdinand Twp	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hospital		d. STREET ADDRESS (If outside, give location) 2044 Kappel Lane	
3. NAME OF DECEASED (Type or print) First Middle Last EARL O RICHARDSON		4. DATE OF DEATH Month Day Year September 10th, 1963	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/28/05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (City and state or country) Buckeye Ark		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Richardson		13b. MOTHER'S MAIDEN NAME Jane Cummings	
14. NAME OF HUSBAND OR WIFE Louise Richardson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no	
16. SOCIAL SECURITY NO. 926		17. INFORMANT Louise Richardson, 2044 Kappel Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural causes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH Unk	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her alive on _____. Death occurred at DOA Co. Hosp. 3:49 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Raymond H. Hark Coroner		22b. ADDRESS Clayton, Missouri	
22c. DATE SIGNED 9/16/63		23a. BURIAL, CREMATION, REMOVAL (Specify) burial	
23b. DATE 9/13/63		23c. NAME OF CEMETERY OR CREMATORY Lake Charles	
23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		24. FUNERAL DIRECTOR ADDRESS DIEDRICH FUNERAL HOME, 8319 Halls Ferry	
25. DATE RECD. BY LOCAL REG. 9-10-63		26. REGISTRAR'S SIGNATURE John C. Murphy Md.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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On 11 June 1997, the author, in company with

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Signed _____

Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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Ex'line

Figure 1

WFO:JLH:GEC:100-104-20-10